

Objections to hospital philosophers

William Ruddick and William Finn *New York University*

Authors' Abstract

Like morally sensitive hospital staff, philosophers resist routine simplification of morally complex cases. Like hospital clergy, they favour reflective and principled decision-making. Like hospital lawyers, they refine and extend the language we use to formulate and defend our complex decisions. But hospital philosophers are not redundant: they have a wider range of principles and categories and a sharper eye for self-serving presuppositions and implicit contradictions within our practices. As semi-outsiders, they are often best able to take an 'external point of view,' unburdened by routine, details, and departmental loyalties. Their clarifications can temporarily disrupt routine, but can eventually improve staff morale, hence team practice and patient welfare.

For a decade philosophers have been admitted to American hospitals as lecturers, committee members, case conferees, and 'philosophers-in-residence'. This collaboration was initially implausible: standard stereotypes cast physicians as intuitive, taciturn practitioners and philosophers as impractical, garrulous theorists. Physicians, we are told, are committed to the welfare of individual patients, and hence to the principle *Primum non nocere*. Philosophers are reputedly committed instead to the truth of general *a priori* propositions. If they subscribed to any occupational principle it would be *Primum non fallere* (above all, do not mislead). How, it was asked, could therapists and theorists possibly collaborate in the clinic or classroom?

Whatever validity these familiar stereotypes once enjoyed, they have been rendered foolish by novel professional circumstances and interactions. Physicians no longer practise solo, taciturn medicine: they are forced by insurers, lawyers, other colleagues, and even patients to explain particular clinical decisions and hospital policies. And academic philosophers no longer talk and write solely for themselves and other abstraction-addicts: they can be found working with politicians, police, and business

corporations (1).

Hence, physician-philosopher collaborations no longer seem implausible. Indeed, they are no longer an oddity: many hospitals and medical schools have some 'philosophic presence', however occasional (2). But, of course, many physicians and other staff members remain doubtful if not hostile.

We wish to address here some of the doubts we have encountered, suspected, or harboured ourselves in the medical centres we know best, as well as some criticisms already in print (3). Although American and British medical centres and education differ, our respective conceptions of medical and philosophical practice are, we believe, similar enough to give these reflections some transatlantic relevance.

Specific objections may be grouped under two main charges, namely, philosophers are either *redundant* or *disruptive* (or both). Redundancy is a serious objection when space, time, and money are in short supply, as they usually are. But even in those few hospitals enjoying happier circumstances, disruption of routine is unwelcome. Hence these charges must be carefully weighed, without caricature or special pleading. On reflection, I tend to think that redundancy, although a plausible suspicion, reflects a common confusion of philosophy with other activities. Disruption is the more justifiable concern: philosophers' questions and distinctions may render routines less defensible and decisions less routine.

Redundancy

The charge of redundancy is less common. But by examining it first, we will have a better sense of the kinds of disruption philosophy fosters, whatever the temperament and social graces of particular philosophers. The charge of redundancy may be stated briefly as follows: Hospitals are staffed by many morally motivated and sensitive people. If moral guidance is needed, there are several readily available resources: colleagues and more experienced superiors; professional principles of ethical conduct; lawyers and clergy; and hospital review committees. Philosophers would at best duplicate these various resources.

Let us expand and consider these claims one by one.

1) 'Members of staff have moral motivations and personal codes of conduct, developed from childhood

Key words

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by parents, teachers, religion, the law, and clinical training and responsibilities. If this training has been faulty, philosophical instruction will not remedy moral flaws of character or principle.'

Despite recent studies, we know very little about moral development – its rate, its stages, its determinants. It may be that, like the pituitary, moral character is fully formed and functioning by late adolescence. (Freudian and Piagetian accounts would support such an analogy.) And it may also be that little improvement is possible, especially by philosophical admonition. The more pressing issue, however, may be that of moral *degeneration*. Critics of American medical education charge that students are selected primarily on the basis of academic skills and drive to excel, not on capacities for care. And however sincere their professed ideals of service, students often find the daily routine, hospital hierarchy, and competition morally debilitating. For many the overriding concern becomes survival; for others it is promotion up the pyramid of academic medicine.

If there are such 'environmental insults' to moral character, then protective measures are called for. Could some kind of philosophical 'instruction' help students and staff maintain their moral motivations? And more generally, could it aid those hospital staff whose moral motivations were as high (and durable) as claimed in the objection we are considering?

Moral philosophy is mistakenly assumed to be a form of moral criticism and exhortation, the secular analogue of priestly instruction. If philosophy leads to such judgements, it does so indirectly. The primary concern of moral philosophers is moral reasoning, not conduct. Their typical questions are not 'What is the moral thing to do in these circumstances?', or 'Was that an honourable decision?' but rather:

'What, morally speaking, can be said for and against this particular option?'

'What considerations are morally relevant or irrelevant?'

'What principles bear on the case, and how, if they conflict, can these principles be weighted or ordered?'

'Who are the appropriate people to decide the matter, given the issues involved?'

These are second-order, or procedural questions about decision-making and decision-defending – the stock-in-trade of philosophy.

Someone may be morally motivated, but unable to answer such questions. Likewise, someone may have high ideals, but be uncertain of their application to particular cases. ('I don't lie to patients, but I don't know whether withholding information from a patient who doesn't ask for it is really lying.')

Training for the 'health sciences' makes little time for such matters, or for the study of biography, literature, and other 'liberal arts' which expand and refine our range of concepts for human feeling and action. Accordingly, hospital staff often lack not only a

clear statement of principles, but the very language in which to try to formulate such principles. Children tend to have only two moral notions, namely, *unfairness* and *meanness*. Most adults, if pressed for moral description, can draw on a slightly expanded repertoire of moral notions (*right*, *correct*, *fitting*, *responsible*). Philosophers, too, have had an equally restricted moral vocabulary. For half a century, the emphasis was on a very few notions (*right*, *good*, *justice*) and on attempts to define them in 'naturalistic,' non-moral terms, or to deny them general, 'cognitive' definition altogether. But this 'meta-ethical' phase has recently given way, partly by reaction, to robust 'substantive' ethics in which a wider range of moral notions and theories is being explored. The traditional and other virtues are back on stage, for example: hope, courage, fidelity. So, too, are friendship, moral integrity, and veracity.

Besides helping people to articulate and apply their moral principles, philosophers are experienced at detecting and reconciling conflicts of principle. If there are, as claimed above, large numbers of hospital staff with personal codes shaped by individual experience, then there are likely to be many such conflicts. However uniform their training, physicians (or nurses, or social workers) vary as to backgrounds and self-reflection; hence their personal codes will differ. (Witness differences on such matters as abortion, candour, euthanasia). Philosophers, as principle-mongers, are also experienced principle-adjusters.

2) 'But', it may be objected, 'these philosophical services are already available through the professional organisations to which hospital staff belong. The professional codes of conduct supplement the deficiencies and conflicts of personal codes. Judicial councils regularly revise and apply these principles to the problematic cases of the time, and thereby provide articulation and guidance.

'Such revisions and applications rightly arise within the profession from practitioners with first-hand knowledge of a physician's responsibilities and temptations, and the complexities of hospital life. Philosophers, even if in full-time medical centre residence, can only mimic this knowledge, and their ethical reflections can at best duplicate, and at worst ignorantly contradict the professional commentaries.'

We readily admit the importance of first-hand clinical experience and the risks of semi-ignorant intrusiveness, even if well-intentioned. First-hand experience, however, may not only be insufficient for adequate moral reflection, but also impose unrecognised limitations. In general, it is difficult to gain self-knowledge of one's own conduct unaided, or even with the aid of close associates engaged in similar pursuits. We have self-protective and group-protective methods which limit the depth and scope of self-examination. We want to think well of ourselves, singly and collectively, and to continue in good conscience to exercise our talents and skills. Hence, we tend to conflate our interests with the interests of those people we 'serve' – our children, our clients, our

patients, our students. By submerging possible conflicts of interest, we keep morality at bay, or even disguise self-interest as altruism. A 'service profession', such as medicine or nursing, is especially prone to such conflation, even when those people being 'served' demur. A patient's assessment of his or her own interests is, as we well know, often overruled by the physician's or nurse's assessment. And although such paternalistic practice is often justified, it requires constant supervision to prevent the self-serving abuses it inherently invites. Outsiders, unprejudiced by hospital routines and associations, can play a useful part in that supervision.

Mounting outside criticism (and legal pressure) has recently led to significant revision of the American Medical Association (AMA) Principles of Medical Ethics (4). For the first time physicians are urged to respect the *rights* of patients, as well as the *rights* of 'other health professionals'. Admittedly, the rights to be respected are barely sketched, but their mere mention invites 'outside' commentary. Rights are claims for aid or non-interference from those with superior goods or strength. As such the delineation of rights should not be left to those against whom those claims may be urged. If these changes are not rhetorical window dressing, then patients and 'other health professionals' will have to be allowed some part in defining the interests these rights are to foster.

Revisions and rights apart, even codes defined solely by professional bodies invite 'outside' input. Codes are partly addressed to those whom professionals serve: they state general ideals and specific prohibitions by way of reassuring clients that their interests will be served. (Witness the Hippocratic general injunction to help, or at least do no harm, and the specific prohibitions on gossip and seduction). Clearly, patients, and potential patients have much to say about the fears that such codes should address.

At a deeper level, there are questions of justification. Some code entries may be prompted by client anxiety or legal pressure. But they and other candidates for inclusion or elimination invite more general justification. What, for example, is the source of patient rights? – a question that we must face as soon as we try to apply general principles to cases. Without justifications, we may be at a loss as to which specific patient rights to recognise.

It is here that moral theories unavoidably enter. Philosophers may be helpful in the 'outside' criticism and revision of existing professional codes. Even if they are not experienced patients or 'health professionals', they are versed in formulating general principles, avoiding ambiguity and redundancy, and other code-writing tasks. But they have no monopoly on clear writing. Their unique qualifications are more theoretical, namely, skills at formulation and criticism of moral theories upon which codes depend for their contents and rationale.

3) 'But', our hypothetical critic replies, 'theology and law also provide theoretical justifications for

human conduct, in terms of spiritual and temporal law, respectively. These are familiar justifications for most hospital staff, as are the clergy and legal advisers who may draw on these justifications in supporting their judgements of particular cases. How could philosophers, even if allowed to swell the ranks of theoreticians, improve upon these theoretical resources?'

Philosophy and religion have been historical friends and adversaries. Roman Catholic theology and rabbinical commentary provide examples of high philosophical ambition and casuistry. But even religiously-inclined philosophers tend to reject the authority of the Bible and appeals in moral argument to God's existence and will. Such appeals too often cut argument short, and, of course, carry no weight with people who do not share their metaphysical presuppositions.

The clergy *qua* clergy therefore cannot be enlisted as resolvers of moral disputes or uncertainty, except perhaps in their respective sectarian hospitals. And even there, many patients and some physicians may not share the hospital staff's predominant religious beliefs. It is therefore desirable that discussion of cases and policies proceed to consensus, if possible, without religious premises or categories. Philosophers outside the religious tradition are well qualified for aiding such discussions, as well as for identifying unstated presuppositions which may be limiting the range of relevant moral considerations.

The law, likewise, provides limited and limiting aid for moral reflection in medicine. Philosophical and legal thought have much in common: the concern for clarity, distinctions, the mutual accommodation of principle and case. But, like appeals to religious beliefs, appeals to a constitution and to legal precedent are too confining and too quick. And, of course, like scripture, any durable constitutional provision or legal principle is general or flexible enough to allow various interpretations and applications. Moreover, even if lawyers may say what the law (in a particular jurisdiction) happens to be, philosophers – and many physicians – want to know whether the law is morally defensible, and how. (Indeed, the new AMA principles commit physicians to working for the revision of any regulations that fail to serve patients' interests).

In short, although the law is always of interest and moral relevance, it is rarely morally decisive. Increasingly interested in law, philosophers are often well qualified to discuss questions the law raises but leaves unresolved.

4) 'But surely', the objector continues, 'hospital committees are the appropriate forum for clarifying and resolving moral uncertainty and dispute. It is they who already have the authority and time to consider, review, censure, and alter hospital practices (5). Composed of various medical specialists, administrators, lawyers, and community representatives, these committees can readily escape the limits of any particular perspective – legal,

religious, or otherwise. Philosophers claim to take a broad view, but committees representing various interests can, collectively, take such a view. What then, would philosophers add?

A variety of viewpoints or approaches may produce blurred rather than broad vision. As anecdotal evidence seems to show, whatever a committee's collective powers, philosophers are especially good at clarifying issues. Even if other committee members happen to be equally able in analytic reasoning and moral casuistry, philosophers – by virtue of their somewhat alien perspective and status – enjoy a judicious distance uncomplicated by personal or departmental special interests or rivalries. (It is striking how much time in a medical centre is devoted to issues of power. Machiavelli would find medical centre politics fascinating – unless they proved too familiar). Moreover, philosophers often have more time for preparation and further reflection than other members of such committees – a benefit of their lack of clinical responsibilities.

We are stressing here the virtues of philosophers' admitted deficiencies: in a world of practical people deluged by data and demands for immediate decisions, there is a role for someone *without* clinical responsibilities, *without* all the details, *without* fear of mistake and malpractice, namely, that of sympathetic observer committed to clear description of moral aspects and reasons. Steeped in routine and hierarchy, people are often unable to see or say what they are doing. Outsiders enable us to take, on occasion, an external point of view of our own practices. From this perspective, we are better able to assess demands for, and resistance to reform.

Disruption

Time out for such reflection is obviously an interruption. And interruptions may produce disruptions. Are philosophers disruptive?

Some philosophers, anxious to show they are not redundant, may ostentatiously resort to their stock-in-trade: moral theory, general principles, counter-examples, distinctions, definition, qualifications, and remote analogy. They thereby give credence to the popular view of philosophers as abstract, disputatious, impractical, tending to favour *a priori* reasoning, and overbearing – in short, disruptive presences on committees with little time and many decisions to make.

But is such disruption intrinsic to the discipline, inescapable even by modest, circumspect philosophers? Philosophy is a form of thought and discourse in which generality, clarity, relevance and reasoning are given excessive weight by any other standards except those of law. And, indeed, philosophers in hospitals often find lawyers kindred spirits. But there is at least one striking difference: lawyers are committed to keeping their clients out of trouble. Like other hospital associates, they have

strong institutional commitments. Philosophers, by contrast, are suspected of trouble-making, and of being unsympathetic to institutions and those who wield power. The 'external point of view' mentioned above tends to reveal points of arbitrary, inefficient, and self-serving behaviour. And unlike sociologists who look for, or assume a deeper functional value of such behaviour, philosophers are more prone to favour reforms to bring practice into rational alignment with institutional ideals.

There may be worries about trouble-making from without, as well as within the hospital. Unlike physicians and lawyers, philosophers take no pledges of confidentiality. If, as is often the case, philosophers teach classes outside a medical centre, will they make indiscreet use of clinical material? Will they violate patient of committee confidences for the sake of realistic examples in their philosophy classrooms? Or worse, will they lend themselves, wittingly or otherwise, to public criticism or even to malpractice suits?

The temptation to reveal the workings of an inner sanctum is undeniable, especially for philosophers who think of themselves as courageous devotees of the Truth. But there are, we think, some reassuring occupational curbs. Unlike historians or literary scholars, philosophers are not anecdotalists by trade. As the old adage puts it '*For example* is no argument'. Moreover, current philosophers in the English-speaking world are in a tradition critical of philosophical grandiosity: claims to discover and reveal the Truth are not taken seriously. What analytic philosophers immodestly claim to discover and dispel is Confusion or Ambiguity. And although they may be as insufferably arrogant as their Truth-seeking predecessors, they are by that token less given to prophetic denunciation. Confused, or inarticulate practice provokes less indignation and interest than do charges of Moral Blindness, or of Reductionist mistreatment of patients. Those latter charges are more likely to be made by religious observers.

Finally, we should correct one stereotype we have been drawing upon: the Philosopher-as-Outsider. The philosophers in question are all products of university doctoral programmes and full- or part-time employees of philosophy departments. Although less 'socialized' than physicians by these educational and occupational experiences, professional philosophers – even those attracted to such marginal topics as medical ethics – are well versed in the demands of co-operative life and institutional loyalties. They, too, are 'professionals' – even if theirs is not conceived as one of the 'helping' professions.

One of their friendly critics has warned hospital philosophers, whom he refers to as 'humanists', to avoid reformist ambitions. If they want to reform medicine

'they should do so through the political process and not on the wards. This does not mean that humanists

should not ask probing questions; however, they should be cautious in making negative judgements in view of their limited knowledge, experience, and accountability. We should be conscious of the danger of programs which, under the guise of "medical ethics", embark on a course of moral reform of the medical students, health professionals, or the particular institutional practices of the hospital within which the program is located. The proper concern of humanists working in this setting should be the analysis of difficult issues rather than moral exhortation'(6).

We would agree with his advice regarding moral exhortation. But there are less direct, more civil means of moral reform. Self-knowledge is a prerequisite of any desire to 'reform', and philosophy has, since Socrates, sought to increase our understanding of our thought, our language, and the actions they determine or discourage. If hospital philosophers seek to increase this kind of self-knowledge, as a prelude to moral reform from within an institution, we see no objection. Nor do we see the harm if such reflection and subsequent reforms disrupt temporarily or intermittently the entrenched routines of hospital care. We assume that hospital staffs are morally motivated and derive satisfaction in their taxing work from the sense of 'doing good'. The kind of self-scrutiny philosophy induces can enhance these satisfactions, as well as enabling co-workers to articulate and reconcile moral differences.

Our friendly critic also warns against the presumption that 'humanist instruction' has been shown to improve the quality of care provided to patients. He allows that philosophers may confuse physicians and that philosophical reflection may 'interfere with the clinician's discernment and intuitive judgement' (7). This is, we agree, a danger to consider. But a clinician's 'discernment and intuitive judgement' are exercised within a social complex that may resist their execution. Staff will often need to know the rationale, including the moral reasoning, for a clinical course of action. And even if philosophical reflection produces some confusions, it also creates new possibilities for their relief. People often work better together when they know the extent of their moral agreement and disagreement, as well as ways in which differences can be discussed.

As for patient welfare, the direct benefits of philosophical reflection are indeed difficult to assess and, given the complexity of causal judgements, always will be: so too, incidentally, may the direct

benefits of many existing scientific parts of the medical curriculum be difficult to assess. Philosophical reflection may more directly enhance patients' rights which in turn may, or may not enhance patient welfare. But if staff morale benefits from occasional disruption and revision of routine brought on by philosophical reflection, then patient welfare may improve indirectly.

We conclude that philosophers in hospitals are not redundant, and that their judicious interventions may, even if disruptive, enhance staff morale and patient welfare.

References and notes

- (1) These changes, their causes and consequences are briefly surveyed in Ruddick W. Philosophy and public affairs. *Social research* 1980; 47, 4: 734-748.
- (2) Some medical schools have 'medical humanities' departments with one or two philosophers full-time. At older medical schools philosophers are more likely to have part-time appointments. Most common, however, is a philosopher sitting on committees reviewing research proposals, care of incurably ill patients, and other problematic cases.
- (3) See for example Swales J D. Medical ethics: some reservations. *Journal of medical ethics* 1982; 8: 117-119, 127, and a reply by Arras J D and Murray T H. In defence of clinical bioethics. *Journal of medical ethics* 1982; 122-127. Also see Philosophers in medical centers. *Hastings Center* report 1981; 11: 2, especially Siegler M. Cautionary advice for humanists. *Hastings Center report* 11: 19-20. For an early self-critical review of 'philosophers-in-residence' at two New York medical centres, see Ruddick W M, ed. *Philosophers in medical centers*. Society for Philosophy and Public Affairs, 1980. Copies may be obtained from the author of this paper at the Dept of Philosophy, New York University, 19 University Place, Room 305, Washington Square, New York, NY 10003, USA.
- (4) AMA opinions and reports of the judicial council, 535 N Dearborn St, Chicago, Illinois 60610, USA.
- (5) Institutional Review Boards are now established and accepted, however reluctantly, in every American hospital receiving government funds for research. These boards ('IRBs') have the authority to review and reject research proposals on grounds of inadequate scientific design and/or inadequate procedures for securing informed, voluntary consent from patients for any proposed experimental procedures. In addition some hospitals have now established hospital ethics committees to consider and advise on ethical issues other than those arising from research proposals.
- (6) See reference (3) Siegler M: 20.
- (7) See reference (3) Siegler M: 19.